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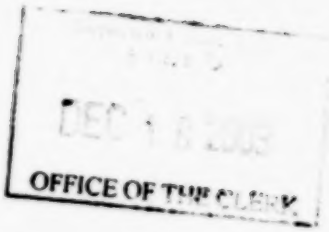

IN THE
Supreme Court of the United States

AETNA HEALTH INC. F/K/A
AETNA U.S. HEALTHCARE, INC., ET AL.,
Petitioners,

v.

JUAN DAVILA,
Respondent.

&

CIGNA HEALTHCARE OF TEXAS, INC. D/B/A
CIGNA CORPORATION,
Petitioner,

v.

RUBY R. CALAD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS AS AMICUS CURIAE SUPPORTING REVERSAL

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INTEREST OF THE AMICUS CURIAE

The Association of Federal Health Organizations ("AFHO") is a trade association of employee organizations and other entities that sponsor experience-rated fee-for-service health benefits plans governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. FEHBA is the federal statute authorizing the United States Office of Personnel Management ("OPM") to establish and regulate health benefits plans for federal employees, retirees, and their dependents. Under FEHBA, a plan is experience-rated if its premiums are based on that plan's historical cost of providing benefits to its enrollees. *Id.* § 8902(i). AFHO's members sponsor some of the largest FEHBA plans in the nation; collectively, they provide health benefits to nearly five million enrollees.[1]

These cases concern the scope of federal jurisdiction and preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* In prior cases, some federal courts have held that preemption over claims concerning FEHBA plans is co-extensive with preemption under ERISA. *See, e.g., Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 394 (9th Cir. 2002); *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 849-51 (9th Cir. 2002); *Corporate Health Insurance, Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir. 2000), *vacated on other grounds*, 536 U.S. 935 (2002). Oftentimes, these courts have treated "ERISA and FEHBA cases interchangeably." *Botsford*, 314 F.3d at 394.

In light of these courts' similar treatment of ERISA and FEHBA preemption, AFHO has an interest in ensuring that the right result is reached on ERISA preemption in the instant cases. AFHO believes the Fifth Circuit's ruling that

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[1] In accordance with Rule 37.6, AFHO certifies that counsel for a party did not author this brief in whole or in part and that no entity other than AFHO, its members, or its counsel made a monetary contribution to the preparation or submission of the brief.

there is no federal jurisdiction or ERISA preemption in these cases is erroneous, and it accordingly files this brief in support of reversal. In addition, AFHO's position is that FEHBA preemption, in reality, is significantly and appropriately broader that ERISA preemption. Thus, while a decision in favor of ERISA preemption would necessarily mean that similar state law claims against a FEHBA plan would be preempted, a decision unfavorable to ERISA preemption should not inevitably be transferred to the FEHBA setting. AFHO files this brief in an effort to help ensure that, in the event the Court were to hold that ERISA does not preempt the state law claims involved in these cases, the Court does not speak so broadly as to cause inadvertently lower courts reflexively to apply the decision's holding to FEHBA plans. Indeed, if appropriate, AFHO respectfully requests that the Court state that any decision here rejecting preemption is limited to the ERISA context and does not address the scope of preemption under FEHBA or any other federal program.

Counsel for the parties have filed letters with the Clerk of the Court consenting, in global manner, to the filing of all *amicus* briefs supporting either side in these actions.

SUMMARY OF ARGUMENT

A. To determine if ERISA completely preempts state law negligence claims disputing denials of benefits based on lack of medical necessity, the critical question is whether Congress intended ERISA's remedies to challenge such denials to be exclusive. It did. First, this Court has already held that Congress meant for the remedies contained in ERISA § 502 to be the exclusive vehicle for disputing the processing of benefits claims. Nothing suggests that Congress intended a different rule to apply to the processing of health benefits based on medical-necessity determinations. Second, ERISA's preemption section, which makes the subject matter it covers an exclusive federal domain, encompasses Respondents' state law causes of action.

Consistent with ERISA's preemption provision, a cause of action that authorizes relief on account of a plan's determination whether or not to pay for certain treatments or supplies necessarily "relates to" the plan.

Third, ERISA's central goal of ensuring uniform plan administration bolsters the exclusivity of ERISA's remedies for disputing medical-necessity determinations. If state law remedies were available, benefits would differ from state to state depending on a particular state's standards of medical reasonableness. Fourth, that medical-necessity decisions involve the exercise of fiduciary obligations supports the exclusivity of the available ERISA remedies, since the Court has never permitted state law to set the parameters for fiduciary conduct. Though *Pegram v. Herdrich*, 530 U.S. 211 (2000), found a physician's decisions concerning treatment that also affect eligibility for benefits not to involve fiduciary behavior, that decision should not be extended to plans making medical-necessity determinations. Fifth, Congress's recent consideration, but rejection, of legislation that would have allowed causes of action similar to Respondents' helps prove that ERISA as originally enacted was not intended to allow for state law remedies for grievances concerning medical-necessity decisions.

B. While the case for federal jurisdiction and preemption under ERISA is overwhelming, the arguments under FEHBA are even stronger. Consequently, in the event the Court were – despite the force of the ERISA case – to hold that ERISA does not completely preempt Respondents' state law claims, it should limit any such ruling to ERISA plans.

Because FEHBA plans are established via federal government contracts, litigation involving FEHBA plans – unlike disputes involving ERISA plans – implicates "uniquely federal interests" and triggers a relaxed standard for preemption. Additionally, among other considerations indicating a broader preemptive scope under FEHBA than

ERISA are: FEHBA's insistence that a federal agency – OPM – have sole authority to adjudicate benefits disputes; a preemption provision expressly aimed at permitting managed-care programs to thrive; a Congressional desire that there be not only uniform benefits among FEHBA plans but that there also be uniform rates; and recent legislative activity to expand, rather than diminish, FEHBA preemption.

ARGUMENT

I. ERISA COMPLETELY PREEMPTS RESPONDENTS' MEDICAL-NEGLIGENCE CLAIMS

The precise issue involved in these cases is whether ERISA completely preempts, and therefore makes removable to federal court, state law negligence claims challenging a health plan's denials of benefits that are based on lack of medical necessity. This Court very recently clarified the standard for determining whether a federal statute completely preempts state law claims. The "proper inquiry focuses on whether Congress intended the federal cause of action [contained in the federal statute] to be exclusive." *Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2064 n.5 (2003). Thus, if Congress intended ERISA's remedies to be the exclusive means for disputing a plan's denial of health benefits on the grounds of lack of medical necessity, then complete preemption exists. All of the salient factors indicate that, in fact, Congress did contemplate ERISA's enforcement scheme providing the exclusive remedy in such cases.

A. The Court Has Already Held that ERISA's Remedies Are Exclusive as to Similar Claims for Benefits

ERISA's enforcement scheme is set out in ERISA § 502, 29 U.S.C. § 1132. That section establishes six different causes of action for grievances associated with the administration of ERISA plans. For present purposes, the

most notable are the cause of action in § 502(a)(1)(B) available to a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan"; and the causes of action in §§ 502(a)(2) and 502(a)(3) for breaches of fiduciary duty.

The Court has already held that these remedies are "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). Reviewing § 502, the Court said in *Pilot Life* that "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." *Id.* at 54. The Court recently reaffirmed *Pilot Life*, *see Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002), and it has never wavered from the guiding principle that there shall be no "alternate enforcement mechanisms" to § 502. *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)).

The Court has not only held that ERISA's remedies are exclusive, but that they completely preempt state law "causes of action asserting improper processing of a claim for benefits." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 60 (1987). The Court in *Metropolitan Life* held that "a suit by a beneficiary to recover benefits from a covered plan . . . falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63. Finding such suits to be "necessarily federal in character by virtue of the clearly manifested intent of Congress," the Court ruled that that they "'arise[] under the . . . laws . . . of the United States,' 28 U.S.C. § 1331, and

[are] removable to federal court by the defendants." *Id.* at 67.

Unless some special rule is to exist for claims for health benefits where the chief issue is medical necessity, the holdings in *Pilot Life* and *Metropolitan Life* are dispositive of Respondents' claims. Respondents had ERISA remedies available to them, and – under *Pilot Life* and *Metropolitan Life* – those remedies are their exclusive means for challenging their health plans' denials of benefits.

For instance, with respect to Respondent Davila's claim, he could have brought an immediate injunctive action under § 502(a)(1)(B) for benefits or to "enforce his rights under the terms of his plan," if he believed that his health maintenance organization ("HMO") had, in denying him the prescription drug recommended by his physician, erroneously implemented the plan's medical-necessity requirements. The federal court could have issued a temporary restraining order or preliminary injunction compelling the HMO to pay for Vioxx, in the event Davila were correct in his allegations.

Another option would have been for Respondents to undergo the treatment that their physicians recommended and then file a claim for benefits. Put in terms of Respondent Calad's case, she could have sought to pay for the additional time in the hospital and then, invoking § 502(a)(1)(B), filed suit in federal court for reimbursement of her costs. The federal court would have full authority to order the payment of benefits, in the event the HMO misinterpreted the plan's medical-necessity requirements.

Nothing in ERISA suggests health benefits claims involving medical-necessity determinations should be excepted from the holdings of *Pilot Life* and *Metropolitan Life*. Congress ordained that ERISA should encompass both pension and welfare benefit plans, with health benefit plans being among the latter. *See* ERISA § 3(1), 29 U.S.C. § 1002(1) (definition of welfare plan). Nor did Congress anywhere single out any species of benefits denials – such as

those based on lack of medical necessity – for less favorable treatment under ERISA. Without any statutory limitation, § 502(a)(1)(B)'s remedies are available to collect benefits and to enforce and clarify rights under the terms of a plan. So long as medical-necessity requirements are part of an ERISA plan's terms, disputes involving them should fall exclusively within ERISA's enforcement scheme to resolve.

B. ERISA's Preemption Section Confirms That the Statute's Remedies to Challenge Medical-Necessity Denials Are Exclusive

ERISA's preemption provision offers further evidence that, with respect to claims for benefits involving medical-necessity issues, Congress intended the statute's remedies to be exclusive. That section states that "the provisions of [ERISA] shall supersede and preempt any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. ERISA § 514(a), 29 U.S.C. § 1144(a). As is now familiar, this Court has repeatedly emphasized the breadth of ERISA's preemption provision. *See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) (noting that Court has, in its precedents, termed ERISA's preemption section as "clearly expansive," having "a broad scope," having "an expansive sweep," "conspicuous for its breadth," "deliberately expansive," and "broadly worded") (internal quotation marks and citations omitted); *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001).

With the preemption provision, "Congress's intent [was] to establish the regulation of employee welfare benefit plans 'as *exclusively* a federal concern.'" *Travelers*, 514 U.S. at 656 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)) (emphasis added); *accord FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (ERISA "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by

ERISA"). Citing to ERISA's legislative history, the Court has noted that ERISA's provisions "are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" *Travelers*, 514 U.S. at 657 (quoting 120 Cong. Rec. 29,933 (1974) (statement of Senator Williams)).

To be sure, this Court has, in recent years, also emphasized that it begins any ERISA preemption analysis with a "presumption against pre-emption." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997). "[W]here federal law is said to bar state action in fields of traditional state regulation, [the Court has] worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Travelers*, 514 U.S. at 655 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (internal citation omitted). And the Court has added that that presumption is particularly strong with respect to "general health care regulation, which historically has been a matter of local concern." *Id.* at 661.

Notwithstanding that presumption, one of the Court's most recent ERISA decisions held that ERISA's preemption clause encompasses state laws requiring that health plans allow for external review of denials of benefits that are based on medical necessity. *Rush Prudential*, 536 U.S. at 365. In *Rush Prudential*, the Court found it "beyond serious dispute that under existing precedent [the state law] 'relates to' employee benefit plans within the meaning of § 1144(a)," though the Court ultimately held that statute was saved from preemption with respect to insured employee benefit plans because of ERISA's savings clause excepting from preemption state insurance, banking, and securities regulations. *Id.*; *see generally* ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (ERISA's savings clause).

Just as in *Rush Prudential*, this case falls within the parameters of ERISA's preemption provision. If a state law authorizing challenges of medical-necessity determinations to external reviewers "relates to" an ERISA plan, then so too must a state law cause of action that authorizes such challenges in court. In both instances, the state measures become pertinent only when the plan makes a benefits determination, a core ERISA-plan function. Indeed, because so much of the day-to-day administration of health plans is focused on evaluating specified treatment options against plan terms such as medical-necessity definitions or exclusionary language for experimental or investigational treatments, state law medical-negligence claims potentially strike at the heart of what health plans do. Unlike other instances where the state laws at issue, such as state tax measures or wage laws, had only "indirect" impact on ERISA plans, *Travelers*, 514 U.S. at 662; *see Dillingham*, 519 U.S. at 334, state law negligence causes of action aimed at medical-necessity decisions constitute "direct regulation of ERISA plans." *Travelers*, 514 U.S. at 668.

Given, then, that Respondents' claims fall within the area covered by ERISA's preemption provision, an area that Congress intended to be of *exclusive* federal concern, it follows that Congress would have contemplated ERISA's remedies to be the only ones available for Respondents' grievances. With the test for complete preemption centering on whether "the federal statute[] at issue provide[s] the exclusive cause of action for the claim asserted," *Beneficial Nat'l Bank*, 123 S. Ct. at 2063, the result under ERISA's preemption clause verifies the propriety of complete preemption over Respondents' claims.

C. ERISA's Goal of Uniformity Supports Complete Preemption of Medical-Negligence Claims

Undergirding ERISA's preemption section, as well as the Court's insistence that the states shall not supply

alternative enforcement remedies, is Congress's desire for nationally uniform administration of ERISA plans.

> Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."

Travelers, 514 U.S. at 656-57 (quoting *Ingersoll-Rand*, 498 U.S. at 142); *accord Egelhoff*, 532 U.S. at 150.

The only disuniformity Congress contemplated was through ERISA's savings clause for insurance, banking, and securities regulations. *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 376 n.6 (1999) ("'disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation'") (quoting *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 747 (1985)). But there is no argument in these cases that state law negligence causes of action are insurance laws, and the Fifth Circuit certainly made no such holding. Consequently, Congress's objective of uniformity applies with full force to Respondents' claims.

Holding that ERISA's remedies to challenge medical-necessity denials are exclusive, and thus competent to completely preempt Respondents' claims, furthers Congress's objective of uniformity. To import the various states' standards on what is medically reasonable in particular circumstances would lead to divergent outcomes within ERISA plans. One state's standards might result in a particular treatment being medically necessary; another state, in the very same situation, conceivably might deem a health plan's denial of benefits for lack of medical necessity to be

entirely reasonable. The consequence would be that participants in one state may obtain benefits that are properly denied in another state. Particularly because so many of a health plan's decisions are tinged with medical-necessity considerations, the resulting disuniformity would be pervasive. Deeming ERISA's remedies for medical-necessity denials to be exclusive avoids that subversion of ERISA's fundamental concern for uniformity.

D. A Health Plan's Denial of Benefits Based on Medical Necessity Involves a Fiduciary Determination

Because any denial of benefits by a health plan based on medical necessity involves fiduciary action, ERISA's remedies exclusively should govern. The Court has never held that state law may regulate the behavior of ERISA fiduciaries. And a determination to provide or deny benefits does involve fiduciary duties. A plan owes a "fiduciary duty with respect to the interpretation of plan documents and the payment of claims." *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). In the case of medical-necessity determinations, plans typically apply definitions of medical necessity contained in plan documents, in order to determine whether to pay for or deny benefits for treatment. Moreover, in determining what is and is not medically necessary, plans "exercise[] discretionary responsibility in the administration of [the] plan," which is the hallmark of an ERISA fiduciary. ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). As conduct of a fiduciary, only ERISA's remedial scheme (and, for that matter, ERISA's substantive standards) should control.

That a plan's denial of benefits based on lack of medical necessity involves fiduciary behavior is proven by the detailed claims regulations issued by the Department of Labor ("DOL"). *See* 29 C.F.R. Pt. 2560. These regulations set out specific timeframes for making determinations concerning health benefits, whether the benefits claim is

post-treatment, pre-treatment, concurrent with treatment, or involves urgent care. The DOL regulations also set forth appeal procedures for denials of benefits, including a requirement that, if a denial involves a medical judgment, the plan must consult during the appellate process with a health care professional who is independent of anyone involved in the initial denial. *Id.* § 2560.503-1(h)(3). If medical-necessity determinations did not involve fiduciary decisions, and were instead matters for state regulation, the DOL would have no basis for exercising its authority to establish standards of conduct.

The sticking point, of course, is *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000), where the Court held that an HMO physician's determinations concerning medically appropriate care "are not fiduciary decisions under ERISA." Though the Court's decision there can be cabined to apply only to *initial physician* determinations concerning treatment, the Fifth Circuit in these cases expanded *Pegram*'s holding to encompass subsequent administrative determinations made by the HMO based on medical necessity – determinations that were contrary to the treating physician's initial recommendations. The Fifth Circuit relied on a passage in *Pegram* where the Court suggested that HMOs might never be able to live up to the fiduciary standard. Whereas a fiduciary "must 'act solely in the interest of the patient without possibility of conflict,'" the "entire purpose" of HMOs "is to balance costs against patient welfare." *Roark v. Humana, Inc.*, 307 F.3d 298, 308 (5th Cir. 2002) (quoting *Pegram*, 530 U.S. at 233).

The Fifth Circuit's extension of *Pegram* from a situation involving physicians to circumstances involving HMOs or other entities administering ERISA plans was misguided. Contrary to the Fifth Circuit's holding (and even to the suggestion in *Pegram*), the mission of HMOs and other health plans is consistent with ERISA's fiduciary obligations. The duty of a health plan fiduciary is not simply to act singly

with an eye toward a patient's wishes; rather, "[t]he common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of *all* beneficiaries." *Varity*, 516 U.S. at 514 (emphasis added). Where an HMO applies the medical-necessity definition contained in plan documents (as it must under ERISA's fiduciary responsibilities, ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D)) and, in so doing, denies a participant's preferred treatment option in favor of a less expensive one deemed to be medically appropriate, the HMO conserves resources for the benefit of all beneficiaries. That is not simply the "ration[ing]" of care for rationing's sake, but the efficient balancing of cost and treatment considerations, as the ERISA plan sponsor likely anticipated would occur when it purchased HMO coverage. *Roark*, 307 F.3d at 308; *see* ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (providing that fiduciary decisions must take into account the interests of all participants and beneficiaries).

In sum, a health plan's evaluation of a physician's recommended treatment regimen, for compliance with medical-necessity requirements, implicates ERISA fiduciary duties. Because the plan determinations involved in these cases therefore involved fiduciary action, ERISA's enforcement scheme is the exclusive remedy for disputing the determinations.

E. Congress's Consideration of Legislation to Permit Medical-Negligence Claims Against ERISA Plans Proves That ERISA Currently Does Not Countenance Such Claims under States Law

Congress's recent consideration of legislation to limit ERISA preemption and allow for state law medical-negligence claims against health plans further illustrates that – in its original enactment of ERISA – Congress

intended the federal remedies to be exclusive. In this regard, Congress has, in recent times, repeatedly considered so-called "Patients' Bill of Rights" legislation. *E.g.*, H.R. 2563, 107th Cong. (2001); S. 1052, 107th Cong. (2001); H.R. 2990, 106th Cong. (1999). These bills, to varying degrees, would have lifted the umbrella of ERISA preemption to allow for state law medical-negligence claims against ERISA plans whose benefits determinations involve medical judgment and allegedly were erroneous.

Congress would have no need to consider such legislation if, in fact, ERISA as currently in force permitted state law challenges to medical-necessity decisions, in addition to the available federal avenues for relief. Merely because Congress has not been able to agree on any changes to the current preemption structure does not mean the Court should, through judicial decision, adopt what Congress so far has not. As it stands now, the remedies for disputing a denial of benefits based on lack of medical necessity are exclusively contained in § 502. Because the federal remedies are exclusive, they completely preempt Respondents' claims, and federal jurisdiction should have been exercised in these cases.

II. FEHBA PROVIDES EVEN MORE SUBSTANTIAL GROUNDS THAN ERISA FOR COMPLETE PREEMPTION OF MEDICAL-NEGLIGENCE CLAIMS

Various considerations, then, lead to the conclusion that § 502 provides the exclusive remedy for ERISA disputes involving denials of health benefits based on lack of medical necessity, with exclusivity, in turn, being the prerequisite for complete preemption. These same considerations – ranging from judicial prohibitions against alternative enforcement schemes, to the text and policies of the pertinent preemption provision, to legislative action – even more clearly favor the exclusivity of the available remedies under FEHBA. Thus, a

finding in these cases in favor of complete preemption under ERISA necessarily should lead to a similar finding for FEHBA plans. The converse, however, does not follow. Because federal jurisdiction and preemption are more readily secured under FEHBA, a ruling that ERISA does not completely preempt Respondents' claims should not answer the question whether FEHBA completely preempts a dispute involving a denial of benefits based on medical-necessity criteria.

A. One overarching factor making FEHBA a stronger candidate for complete preemption than even ERISA is that the threshold for preemption is markedly lower in FEHBA cases than in ERISA matters. FEHBA covers an area of "uniquely federal interest"; and in areas of uniquely federal interest, "[t]he conflict with federal policy need not be as sharp as that which must exist for ordinary pre-emption when Congress legislates 'in a field which the States have traditionally occupied.'" *Boyle v. United Techs. Corp.*, 487 U.S. 500, 507 (1988) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). "Or to put the point differently, the fact that the area in question *is* one of unique federal concern changes what would otherwise be a conflict that cannot produce pre-emption into one that can." *Id.* at 507-08; *see also Buckman v. Plaintiffs' Legal Committee*, 531 U.S. 341, 347-48 (2001).

FEHBA authorizes OPM to contract with private carriers to provide health benefits for federal employees, retirees, and their dependents. 5 U.S.C. § 8902(a). Accordingly, FEHBA plans are established through federal government contracts. "No insurance contract exists . . . between the [enrollees] and [their FEHBA plan]"; "[i]nstead, the [individuals] are enrollees in a federal health insurance plan underwritten by [the carrier] and are subject to regulations promulgated by OPM." *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1030 (E.D. Tenn. 1999); *accord Caudill v. Blue Cross & Blue Shield of N.C.*,

Inc., 999 F.2d 74, 76 (4th Cir. 1993). The government pays the majority of the premium price for enrollees, with the enrollee paying the remainder. 5 U.S.C. § 8906.

FEHBA leaves to OPM the task of selecting the benefits that a particular FEHBA plan shall provide. The statute directs OPM to procure such health benefits as the agency "considers necessary or desirable." 5 U.S.C. § 8902(d). In conjunction with this authority, OPM issues to all enrollees in each FEHBA plan a "Statement of Benefits." *See id.* The Statement of Benefits sets forth the "benefits, including maximums, limitations, and exclusions"; the "procedure for obtaining benefits"; and the "principal provisions of the plan affecting the enrollee and any eligible family members." *Id.* § 8907(b). It is part of the government contract governing the FEHBA plan. *See id.* § 8902(d).

Given the government's subsidization, a federal agency's guiding role, and the FEHBA program's effect on the government's own employees, the courts have already held that litigation over FEHBA benefits implicates uniquely federal interests, thereby triggering *Boyle*'s lower preemption threshold. "The interest in [a dispute over FEHBA benefits] is uniquely federal because it involves health benefits for federal employees across the country." *Caudill*, 999 F.2d at 78; *accord Rievley*, 69 F. Supp. 2d at 1037; *Kight v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc.*, 34 F. Supp. 2d 334, 341-42 (E.D. Va. 1999). Thus, "the mere possibility of conflict and attendant damage to federal interests is sufficient" for preemption. *Caudill*, 999 F.2d at 79. Moreover, in *Boyle*, the Court held broadly that "the civil liabilities arising out of the performance of federal procurement contracts" is a matter of "uniquely federal interest." *Boyle*, 487 U.S. at 505 (internal quotation marks omitted). Any judgment against a carrier administering a FEHBA plan likewise constitutes a civil liability arising from the performance of a government contract and therefore should also involve uniquely federal interests.

Because FEHBA cases implicate uniquely federal interests, the Court begins its analysis with an eye toward the preemption of state law remedies. That contrasts with the strongly worded presumption against preemption that the Court has, in recent ERISA cases, invoked.

B. Reminiscent of ERISA, FEHBA does not tolerate "alternative mechanism[s] for enforcing FEHBA-created rights," in addition to FEHBA's remedies. *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 397-98 (9th Cir. 2002). FEHBA contains a "single" remedy for an enrollee to challenge denials of benefits, whether based on lack of medical necessity or for any other reason. *Kight*, 34 F. Supp. 2d at 342; *accord Botsford*, 314 F.3d at 398 ("the federal remedies provided to aggrieved federal employees under the regulatory scheme are the only intended remedies under FEHBA"); *Bryan v. OPM*, 165 F.3d 1315, 1318 (10th Cir. 1999) (under FEHBA, "only one remedy is available"). That remedy, outlined in detail in OPM's regulations, is an administrative appeal at OPM to challenge a carrier's denial of benefits, followed by judicial review in federal court of OPM's final decision either affirming or denying the carrier's initial decision. *See* 5 C.F.R. §§ 890.105, 890.107; 48 C.F.R. § 1652.204-72.

Congress expressly directed that OPM create such a remedy. It instructed that "[e]ach contract . . . shall require the carrier to agree *to pay for or provide a health service or supply* in an individual case if the Office finds that the employee, annuitant, family member, or spouse is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(j) (emphasis added). In light of its directive that OPM shall determine the availability of benefits in individual cases, Congress enacted only a limited jurisdictional provision in FEHBA – for suits against the United States. *See* 5 U.S.C. § 8912 ("The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the

United States founded on this chapter."). Furthermore, considering the fact that OPM – not the carriers – has final responsibility for determining the availability of benefits or services, the agency has prohibited all suits against carriers. *See* 5 C.F.R. § 890.107(c) (noting that challenge to "denial of health benefits must be brought against OPM and not against the carrier or the carrier's subcontractors").

While both ERISA and FEHBA create exclusive federal remedies for disputes over benefits (the benchmark for complete preemption), what makes FEHBA's enforcement scheme even more capable of preemption is that a federal agency – OPM – has the central role. It not only is responsible for selecting the available benefits, but for adjudicating all disputed benefits claims. In delegating such authority to OPM, Congress intended for "consistency" in the manner in which all FEHBA plans are administered. *Caudill*, 999 F.2d at 79. Allowing alternative remedies therefore creates an acute problem under FEHBA: it would "undercut" the consistency that Congress expected and leave to other parties (namely state court judges and juries) the task of interpreting FEHBA plans that Congress expressly expected only OPM to undertake. *Id.*

C. FEHBA contains a preemption provision that is even more pointedly aimed at ousting state law remedies relating to benefits than is ERISA's. The provision, in its current form, states:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State of local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1) (2000).

The current provision, which came into being in 1998 and amended a preemption provision narrower in scope, *see* Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, was specifically designed to invite complete preemption in disputes over benefits. The amendment's purpose was to "confirm[] the intent of Congress that . . . FEHBA program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) *completely displace* State or local law relating to health insurance or plans" and to "strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." H.R. Rep. No. 105-374, at 9, 16 (1997) (emphasis added).

FEHBA's preemption provision is unique in comparison to ERISA's because it turns on the provisions of the federal government contracts that OPM enters with carriers. Whereas the Court has said that private parties to an ERISA plan may not avoid the application of otherwise applicable state law by adding contrary terms to the plan, *see UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375-76 (1999), FEHBA's preemption provision gives the parties to FEHBA contracts (albeit, one of them being the government itself) the authority to draft contract terms "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" that shall unqualifiedly supersede state law relating to health insurance or plans. That is significant for these cases because definitions of medical necessity contained in FEHBA Statements of Benefits automatically would preempt state law standards concerning medical reasonableness, the area that the Court has been careful in its ERISA cases to say will not lightly be disregarded.

Additionally, FEHBA's preemption provision directly addresses the managed-care issues raised in these cases. When it amended FEHBA's preemption section in 1998, one change Congress made was to add that FEHBA contract

terms relating to the "provision" of benefits and coverage shall preempt state law, whereas previously the amendment had focused simply on contract provision relating to the nature or extent of coverage or benefits. *Compare* 5 U.S.C. § 8902(m)(1) (1994) *with* 5 U.S.C. § 8902(m)(1) (2000). Congress added that language in order to make clear "that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, *including managed care programs*." H.R. Rep. No. 105-374, at 16 (emphasis added). With the amendment, Congress sought to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." *Id.* at 9.

Hence, whereas ERISA's preemption provision speaks broadly about preempting all state laws relating to plans, and that text has sometimes proven "unhelpful" and "frustrating" when seeking to determine the exact contours of ERISA preemption, *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995), FEHBA's preemption provision unmistakably addresses the very managed care issues that medical-necessity determinations entail. Consistent with FEHBA's preemption section, state law causes of action may not interfere with the FEHBA plan's determination that the provision of any service or supply is, or is not, medically necessary.

D. Just as Congress sought interstate uniformity in the manner in which an ERISA plan is administered, a chief Congressional goal underlying FEHBA is "uniformity in the administration of FEHBA benefits." *Hayes v. Prudential Ins. Co. of Am., Inc.*, 819 F.2d 921, 925 (9th Cir. 1987); *accord Caudill*, 999 F. 2d at 78-79; *Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993). With FEHBA's preemption provision, and by delegating solely to OPM adjudicatory power over benefits disputes, Congress sought to further that goal. *See* H.R. Rep. No. 95-282, at 1, 4 (1977); *accord* S. Rep. No. 95-903, at 2 (1978), *reprinted in* 1978 U.S.C.C.A.N. 1412, 1413; H.R. Rep. No.

105-374, at 9, 16. In fact, Congress had even greater regard for uniformity in FEHBA than ERISA, because in FEHBA it nowhere included an insurance savings clause. Instead, state laws relating to "health insurance or plans" can be preempted. 5 U.S.C. § 8902(m)(1) (2000).

The operation of state law and its remedies is particularly offensive to FEHBA's uniformity objective because, in FEHBA (though seemingly not in ERISA), Congress expected uniformity not only in the benefits offered, but in the *rates* charged. *See* H.R. Rep. No. 105-374, at 9 (a goal of FEHBA's preemption provision was to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live"). But if state standards of medical reasonableness controlled, it could lead to benefits in one state being deemed medically necessary, but not so in another state – with the enrollees in both states nonetheless paying the same premium costs. "This situation would be fundamentally unfair to many federal employees covered by [the same FEHBA] contracts because enrollees in some states would pay higher premiums to cover services provided only to enrollees in other states." *Caudill*, 999 F.2d at 79; *see also* H.R. Rep. No. 95-282, at 4 (the operation of state law "would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States").

E. None of the issues under *Pegram v. Herdrich*, 530 U.S. 211 (2000), that cloud preemption under ERISA arise in the FEHBA context. Whereas *Pegram* raises the question whether a plan's denial of coverage based on lack of medical necessity constitutes fiduciary action (or, alternatively, is solely a matter for state law governance), the concept of fiduciary duties has no bearing under FEHBA. FEHBA contracts "do[] not fit the traditional trust category." *Christiansen v. Nat'l Savs. & Trust Co.*, 683 F.2d 520, 533 (D.C. Cir. 1982) (internal quotation marks omitted). "[T]he

FEHBA scheme [does] not create fiduciary or trust relationships, but create[s] 'third party beneficiary contracts.'" *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 37, 44 (D.D.C. 1996) (quoting *Christiansen*, 683 F.2d at 530)).

Instead of having any fiduciary obligations, a FEHBA carrier's only duties to enrollees are those created by its contract with OPM, and the enrollees' only rights are those created by "the terms of the plan they subscribed to." *Christiansen*, 683 F.2d at 533. Because the federal government contract is the source of all duties and obligations – not state law or even any body of trust law – there should be no question that federal law exclusively governs the remedies of enrollees for grievances under the FEHBA program.

F. Congress's legislative activity further confirms that FEHBA creates a stronger case for federal jurisdiction and preemption than even ERISA. Whereas Congress has considered (though never passed legislation) amending ERISA's preemption clause to allow for the sort of state law cause of action that Respondents seek to pursue in these cases, FEHBA has not been the source of similar legislative interest. On only one occasion has Congress endeavored to create any sort of remedy for medical negligence in the FEHBA setting. And that proposal was to create an action for damages *against the federal government*, not any FEHBA carrier. *See* S. Bill 1052, 107th Cong., Amendment 850 (offered by Sen. Nickles).

Indeed, while Congress has been considering proposals to alter the scope of ERISA preemption to allow for additional state remedies (though, again, never enacting legislation to that effect), it has actually passed legislation expanding the scope of preemption under FEHBA. The 1998 amendment to FEHBA's preemption section "broaden[ed]" FEHBA's preemption provision, not only to ensure that contract terms relating to the "provision" of

benefits preempt state law, but also to rid the statute of an earlier requirement that only conflicting state law shall be preempted. H.R. Rep. No. 105-374, at 9; *see generally Botsford*, 314 F.3d at 393-94, 399 (summarizing 1998 amendment and its purposes). In FEHBA, Congress has readily, and recently, favored creating an exclusively federal field of regulation.

In short, the case for federal jurisdiction and preemption under ERISA of Respondents' claims is powerful and should result in the reversal of the Fifth Circuit's decision. The case under FEHBA is even more so and accordingly argues in favor of the Court limiting any holding against preemption that might be issued in this case solely to ERISA matters.

CONCLUSION

The Court should reverse the decision of the Fifth Circuit in these cases.

Respectfully submitted,

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